RESOLUTION
OF THE
WHO REGIONAL COMMITTEE FOR SOUTH-EAST ASIA

SEA/RC59/R3 PROMOTING PATIENT SAFETY IN HEALTH CARE

The Regional Committee,

Recalling World Health Assembly resolution WHA55.18 relating to “Quality of care: Patient safety”,

Noting with concern the high human and financial toll of adverse events in both developed and developing nations,

Conceding that the problem is likely to be even greater in developing nations,

Recognizing that most of the harm to patients is due to failures in the design, organization and operation of systems,

Acknowledging that a large proportion of adverse events are therefore preventable,

Noting with concern the potential problems in the Region because of the vicious cycle of adverse events and malpractices, law suits and medical liability insurance, the practice of defensive medicines and the rising costs of health care,

Aware that no single stakeholder has the expertise or delivery capabilities to adequately tackle the full range of patient safety issues, and

Having considered the report and recommendations of the Technical Discussions on Promoting Patient Safety at Health Care Institutions in South-East Asia during the Forty-third Meeting of the Consultative Committee for Programme Development and Management,

1. ENDORSES the recommendations contained in the report (SEA/RC59/11 (Rev.1) and SEA/RC59/Inf.4);

2. URGES Member States:
   (a) to assess the scope and nature of adverse events in health care institutions as well as the contributing factors;
   (b) to establish or improve, with the involvement of all stakeholders, systems for the detection and reporting of adverse events with a primary focus on improving systems;
   (c) to develop national mechanisms to capture, share, respond, and learn from this information at all levels of the health system;
   (d) to promote interventions that have been shown to improve patient safety;
(e) to support and enable health care institutions, both public and private, from the primary health care level through the referral level, to implement systems changes and practices conducive to patient safety;

(f) to create, at all levels of the health care system, through awareness raising and enabling policies and legislation, an open environment receptive to the operational changes needed to deliver safer care in health care institutions;

(g) to engage patients, consumer associations, health care workers, and professional associations, hospital associations, health care accreditation bodies and policy makers, in building safer health care systems, and creating a culture of safety within health care institutions;

(h) to establish systems that respect the rights of both patients and providers, and

(i) to allocate adequate resources to implement the above activities, and

3. REQUESTS the Regional Director:

(a) to coordinate, through an inclusive consultative process, the development of a strategic framework and package of interventions for strengthening patient safety which builds on successful interventions and actions in the Region and worldwide;

(b) to provide strong technical leadership and support to Member States in designing and implementing patient safety interventions and monitoring systems;

(c) to ensure capacity building in different aspects of patient safety through training activities at the regional, subregional, and country levels;

(d) to facilitate collaboration and the exchange of information and best practices between Member States and the World Alliance on Patient Safety;

(e) to coordinate and facilitate research on patient safety in the Region, including baseline surveys on adverse events, and operational research to assess the cost effectiveness of interventions;

(f) to contribute to the development of a patient-safety taxonomy, systems for reporting and learning from adverse events, and best practices to improve patient safety, and

(g) to monitor and report on progress in this area in the Region.